COBRA Guide

2007-2008

Benefit Services Division

Benefit Options

Choice. Value. Health.

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The Benefit Options Guide is designed to provide an overview of the Benefit Options Program and the benefits offered through the State of Arizona. The actual benefits available to you and the descriptions of these benefits are governed, in all cases, by the relevant Plan Descriptions and contracts. The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefit plans at anytime.

WHAT'S NEW FOR PLAN YEAR 2007-2008

There are numerous changes to our Benefit program this year. This is a summary of the changes for our Plan effective October 1, 2007:

Eligibility Change:

One of the most important changes this year is the addition of a new category for "Employee + one dependent." This category or tier of coverage is intended to aid those who formerly had to enroll in the "Family" tier. Examples of persons eligible are: employee and spouse or employee and one child. This tier is not available to unmarried couples or domestic partners. We will request proof of the relationship between those applying for this tier unless we already have the evidence in our files. "Dependent" is defined in the Benefits Enrollment Guide, which is available at *www.benefitoptions.az.gov*.

Plan Design Changes:

Smoking/Tobacco Cessation Aids: To assist members with their efforts to quit smoking, the plan will now reimburse members for smoking/tobacco cessation aids (nicotine patch, nicotine gum, etc.) up to a cost of $500 per lifetime. There are numerous resources available to assist those who wish to quit tobacco use. These resources include the Arizona Department of Health Services Tobacco Education and Prevention Program *www.betobaccofree.org*, Arizona Smoker's Helpline (ASH) program (1-800-556-6222) and the member's County Health Department.

Voluntary and court ordered substance abuse residential treatment: Previously, only hospitalizations for those with chemical and alcohol dependency were covered. Studies demonstrate that residential treatment allows for better treatment and a better success rate. Current costs for acute hospital treatment run over $14,000 per stay, while residential treatment is less than half that cost. Our goal is to increase the likelihood of success for our members while reducing costs.

Encouraged use of generic medications: Physicians have the option of approving the "generic substitution" on prescriptions. When there is a generic available and the member insists the prescription be dispensed as written (rejecting the generic), the pharmacy will ask the member to pay the difference between the generic version and the brand version of the named drug.

This policy change will require more members to choose generic drugs. If there is a medical reason for the brand name drug, the physician should not approve the "generic substitution" option. Accordingly, the member will not be charged the difference if the physician designates "no substitution."

Increase the annual physical examination limit from $250 to $1500: The prior limit was not adequate to cover all lab and diagnostic testing. If these preventative services (yearly physical) totaled more than $250, members were asked to pay the overage.

This change does not change the fee schedule for physicians and laboratories. It is intended to encourage thorough examinations to detect illness or serious conditions earlier.

Approve mammograms annually for women 40-49 years of age: This change models the recommendations from the American Cancer Society. Women 40 years and older are encouraged to receive regular annual screenings.

Increase Emergency Room Co-pays from $75 to $125 per visit: In 2006, Plan members visited emergency rooms over 25,000 times. Many of these services could have been safely provided at an urgent care facility or a physician's office. Waits for non-emergent care at emergency rooms are often three and four times the wait at urgent care centers.

All plans have arrangements with urgent care centers and co-pays for those visits remain at $20. Members can call their plan Nurseline or help number for assistance in deciding whether to seek emergency or urgent care.

Seek emergency care if a life is in jeopardy or permanent loss is imminent.

Raise specialist co-pays from $10 to $20: Many patients seek specialty care when primary care would suffice. When routine conditions are the cause of the visit, specialists generally cost the plan much more than primary care physicians.

Primary care physicians include: general medicine, internal medicine, family medicine, and OB. We encourage members to carefully consider which type of physician is needed before making appointments. Plan Nurseline or triage staff may assist members who are unsure about which level of care to seek.

INTRODUCTION

Benefit Options, the State of Arizona's comprehensive employee benefits package, was designed with you and your family in mind.

In this valuable reference guide, we have included explanations of the benefits programs, important plan information, contact addresses, phone numbers, web addresses, and comparison charts. In this guide, you will find the information you need to make informed decisions regarding the selection and continued management of your benefits.

The Benefit Options Guide is designed to provide an overview of the Benefit Options Program and the benefits offered through the State of Arizona. The actual benefits available to you and the descriptions of these benefits are governed, in all cases, by the relevant Plan Descriptions and contracts. *In the event of discrepancies between this Guide and relevant Plan Descriptions or contracts, including amendments, the contract and plan descriptions prevail.* The State of Arizona reserves the right to modify, change, revise, amend or terminate these benefit plans at any time.

Persons with a disability may request reasonable accommodation by contacting the Benefit Services Division. If you need this information in an alternative format, please call 602.542.5008, option 2.

Important Contact Information

Contact	Phone Number	Web Address	Policy Number
Medical Plans			
Fiserv Health - Harrington Benefits (Arizona Foundation, Beech Street, RAN+AMN, Schaller Anderson Healthcare)	1.888.999.1459	www.myazhealth.com	3J
TDD/TTY	1.866.503.3463		
UnitedHealthcare	1.800.896.1067	www.myuhc.com	705963
TDD/TTY	1.888.697.9055		
Blue Cross Blue Shield (NAU only)	1.928.526.0232 1.800.423.6484	www.bcbsaz.com	Grp #0002 Active
Pharmacy			
Walgreens Health Initiatives	1.866.722.2141	www.mywhi.com	512298
Dental Plans			
Delta Dental	1.800.352.6132	www.deltadentalaz.com	7777-0000
Employers Dental Services	1.800.722.9772	www.mydentalplan.net	6300
Assurant Employee Benefits	1.800.443.2995	www.assurantemployeebenefits.com	EA82
MetLife Dental	1.800.942.0854	www.metlife.com/dental	94739
Vision Plan			
Avesis, Inc.	1.800.828.9341	www.avesis.com	10790-1040
Flexible Spending Accounts			
ASI - Member Services	1.800.659.3035	email: asi@asiflex.com www.asiflex.com	
Life and Short Term Disability Plans			
Standard Insurance Company	1.866.440.4846	www.standard.com/mybenefits/arizona/	617950
Long Term Disability			
Sedgwick, CMS (ASRS Participants)	1.818.591.9444	www.vpainc.com	
Standard Insurance Company (PSPRS, EORP, CORP, OPT RET Participants)	1.866.440.4846	www.standard.com/mybenefits/arizona/	
Other Important Numbers			
ADOA Benefits Office 100 N 15th Ave #103 Phoenix, AZ 85007	1.602.542.5008 or 1.800.304.3687	www.benefitoptions.az.gov email: beneissues@azdoa.gov	
Arizona State University Tempe and Polytechnic campus employees	1.480.965.2701	www.asu.edu/hr/benefits email: askhr@asu.edu	
Arizona State University West and Downtown Phoenix campus employees	1.602.543.8400	www.west.asu/hr/hr.html email: benefitswest@asu.edu	
Northern Arizona University	1.928.523.2223	email: hr.contact@nau.edu www.hr.nau.edu/	
The University of Arizona	1.520.621.3662	email: benefits@email.arizona.edu www.hr. Arizona.edu	

ELIGIBILITY

The following persons may be eligible for COBRA coverage:
An employee who had coverage through the State of Arizona and lost the coverage because of a reduction in hours of employment or a termination of employment for a reason other than gross misconduct.

An employee's legal spouse, as defined by Arizona Statute, who had coverage through the State of Arizona and lost the coverage for any of the following reasons:

- Death of the employee
- Termination of the employee's employment for reason other than gross misconduct
- Reduction in the employee's hours of employment resulting in a loss of eligibility for coverage
- Divorce or legal separation from the employee
- The employee becomes eligible for Medicare

An employee's dependent child who had coverage through the State of Arizona and lost the coverage for any of the following reasons:

- Death of the employee (parent)
- Termination of the parent's employment for a reason other than gross misconduct
- A reduction in the parent's hours of employment resulting in a loss of eligibility for coverage
- The parents' divorce or legal separation
- The parent becomes eligible for Medicare or,
- The dependent ceases to be a dependent child as defined by the Benefit Options program.

The ADOA Benefits Office will determine final eligibility for COBRA coverage.

If you are eligible for COBRA coverage, you have 60 days from the date of COBRA notification or loss of coverage, whichever is later, to elect coverage or you waive your right to COBRA coverage.

Eligible dependent children include:

- Natural, adopted and/or stepchildren under age 19, or under 25 if a full-time student at an accredited educational institution.
- Minors under the age of 19 for whom the employee-member has court-ordered guardianship.
- Foster children under the age of 19.
- Children placed in the employee-member's home by court order pending adoption.
- Natural, adopted and/or stepchildren who were disabled prior to age 19 and a dependent under the Plan at the time of the disability.

Please note: If your dependent child is approaching age 19 and is disabled, immediately contact the ADOA Benefits Office regarding procedures to continue coverage for this dependent. You

will need to provide verification that your dependent child has a qualifying permanent disability, in accordance with Social Security Administration (SSA) guidelines, that occurred prior to his or her 19th birthday. Documentation may be required periodically to include a disabled dependent on your plan. Final eligibility will be determined by the ADOA Benefits Office.

Qualified Medical Child Support Order (QMCSO)
If a QMCSO exists, you must continue coverage for your dependent pursuant to the Order. You may not terminate coverage for a dependent covered by a QMCSO.

How Long COBRA Coverage Lasts
If you lose coverage through the State of Arizona plan because of a termination of employment or a reduction in hours, you and your eligible family members may maintain COBRA coverage for a maximum period of 18 months from the date of the event.

If an employee's spouse and/or covered dependents lose their coverage because

- of the employee's death or entitlement to Medicare
- of the employee's legal separation or divorce the employee's child is no longer a dependent under the Plan

The eligible family members may maintain COBRA coverage for a maximum period of 36 months from the date of the event.

By law, these coverage periods may be reduced for any of the following reasons:

- the State of Arizona no longer provides group health coverage to any of its employees;
- you do not pay the amount due for your COBRA coverage on time;
- you or one of your covered family members become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition; or
- you or one of your covered family members become entitled to Medicare.

Extended COBRA Coverage
In addition, if during or before an 18-month period of COBRA coverage, the Social Security Administration makes a formal determination that you or a covered dependent spouse or child are totally and permanently disabled, so as to be entitled to Social Security Disability Income benefits, the 18-month maximum period of COBRA coverage can be extended for up to 11 more months, for all qualified beneficiaries who have elected COBRA coverage. The cost of coverage during the additional 11-month period of COBRA coverage may be considerably higher than the cover for the coverage for the first 18 months. This extension is available if:

- the Social Security Administration determines that the individual's disability began no later than 60 days after the employee's employment was terminated or his/her hours were reduced; and you or another member of your family notifies the ADOA Benefits Office of the disability determination by the Social Security Administration before the end of the 18-month COBRA coverage period.

Electing Your COBRA Benefits

Upon termination from State Service, employees and eligible dependents will be notified in writing of their COBRA rights and the deadline date for returning their enrollment form(s).

To have the opportunity to continue coverage after a divorce, legal separation, or a child ceasing to be a dependent, the employee and/or affected family member(s) must inform the ADOA Benefits Office in writing no later than 60 days after the event. If notice is not received by the end of that 60-day period, the affected spouse or dependent will not be entitled to choose COBRA coverage. When notified that one of these events has happened, the ADOA Benefits Office will provide the covered dependents with the information and forms needed to elect COBRA coverage. Under the law, the covered dependents have at least 60 days from the date they would lose coverage because of one of the events described above, to inform the ADOA Benefits Office that they want to elect COBRA coverage.

COBRA coverage may be elected for some members of the family but not others (including one or more dependents, even if the employee does not elect it), as long as those for whom it is chosen were covered by the Plan on the date of the event (e.g., termination of employment, death, divorce) that led to the loss of regular coverage. A parent may elect or reject COBRA coverage on behalf of dependent children living with him or her. If one of the dependents elects COBRA coverage for him/herself only, the enrollment form must be signed by that dependent unless the dependent is a minor. When the dependent is a minor, the employee- parent must sign the form.

Changing Your COBRA Benefits

If, while you are enrolled for COBRA coverage, you marry, have a child or have a child placed for adoption, you may enroll that spouse or child for coverage for the balance of the period of your COBRA coverage, provided you do so within 30 days after the marriage, birth or placement. Adding a spouse or child may increase the amount you must pay for COBRA coverage.

A Second Qualified Life Event

If you have a second Qualified Life Event while under COBRA coverage and you were eligible for COBRA coverage as the result of an employee's termination (for other than gross misconduct) or the reduction in hours of an employee, you may be granted an extension of coverage for up to 36 months from the date of termination or reduction in hours. The extension applies only to qualified beneficiaries, including children of the employee who were born or adopted while the employee was on COBRA coverage. (Qualified beneficiaries include an employee's spouse who was covered by the Plan and an employee's dependent children who were covered by the Plan.)

If You and Your Spouse are State Employees

If both you and your spouse are eligible State of Arizona employees, be sure to take into account the coverage that you each can elect.

Under no circumstances may an employee elect dual coverage. If it is determined there is dual coverage, you will be responsible for coordination of benefits for any claims paid under your dependent status. Health insurance premiums will not be reimbursed to either employee as a result of dual coverage.

ENROLLMENT

Initial Enrollment

- Fill out the COBRA Enrollment form.
- Send it into the ADOA Benefits Office within 60 days of your eligibility event.

Remember

- To sign and date your completed COBRA Election Notice
- To keep a copy of your completed COBRA Election Notice

Your Contributions to Benefit Options

What Do You Pay?

By law, while on COBRA coverage, you will have to pay the total cost of your COBRA coverage. You are charged the full amount of the cost for similarly-situated employees or families – both the employee's and the employer's portion - plus an additional 2% administrative fee.

When Do You Pay?

You must make the first payment within 45 days of notifying the plan administrator of selection of COBRA coverage. Thereafter, premiums are due on the first day of each month of coverage. After your first premium payment, you may have a grace period of 30 days from the usual due date to pay the premiums

How Do You Pay?

Payments for COBRA coverage are made directly to the individual plan vendors. Each vendor will bill you for your coverage. All payments must be made out to the vendor. ADOA cannot process these payments.

ADOA and your vendor will not be able to confirm that you are entitled to covered services until the vendor has received your premium for the month in which the care is to be provided.

Medical Plan Information

What plans are available for me to choose from?
There are two types of medical plans offered for COBRA employees. They are the Exclusive Provider Organization (EPO) and the Preferred Provider Organization (PPO).

If you choose an EPO you must obtain services from a contracted provider in your network and your cost is a minimal co-pay. The EPO plans are:

- RAN+AMN
- Schaller Anderson Healthcare
- UnitedHealthcare

If you choose a PPO it allows in-network and out-of-network treatment. If you obtain treatment out-of-network, you will need to meet a plan year deductible and pay a percentage of all covered services. The PPO plans are:

- Arizona Foundation
- United HealthCare
- Beech Street (Out of State)
- BlueCross BlueShield (NAU Only)

What is the cost of medical coverage?
Please refer to your enrollment form for information regarding monthly premiums.

How do I find in-network (contracted) providers with my medical plan?
You can perform a provider search on the network web site, or you may call the network customer service line.

When does my coverage become effective?
Initial enrollment in COBRA coverage is made effective the day after active coverage is terminated.

Changes made during Open Enrollment 2007 will become effective October 1, 2007.

When will I receive my ID cards?
ID cards typically arrive seven to fourteen business days after your benefits become effective.

ONLINE FEATURES OF MEDICAL PLAN INFORMATION

Members can now review their personal profiles, view the status of medical claims, obtain general medical/pharmacy information, and learn how to manage their own healthcare through the available health plan websites.

Arizona Foundation, BeechStreet, RAN+AMN, Schaller Anderson Healthcare
Members enrolled with any of the providers above may view the following information on *www.myazhealth.com* (you will need to register with a user name and password):

- **Personal Profile** Check your eligibility status and personal profile.
- **Claims Inquiry** View and read the status of all medical claims submitted for payment, including billed charges; any deductibles or co-pays made; the amount paid to the provider; and details on provider payments.
- **Deductible Status** View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums
- **Secure Mail** With the "Secure Mail" feature, you may ask questions anytime day or night. You will receive replies about your confidential health benefit information within 3 business days without the worry of transmitting your personal information over the internet.
- **Health Information** Compare hospitals based on quality of care, procedures and patient safety measures. You may also view a medical encyclopedia, information on general health topics, and an outline of questions you should ask your doctor.
- **Medline Plus** Medline Plus provides extensive health information on over 650 diseases and conditions; offers a medical dictionary and encyclopedia; contains information on clinical health trials; and features the latest medical research in medicine.
- **Provider Search** You may click on your network to research contracted network physicians, hospitals, and medical providers.
- **Provider Information** You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure e-mail feature.
- **Claim Forms** You may download claim forms and information to submit claims for medical services and reimbursement for out-of-pocket expenses.

For the NAU only BCBS PPO plan details, go to http://hr.nau.edu/m/ *and choose Benefits, Health, BCBS Plan Book.*

UnitedHealthcare

If you are enrolled in UnitedHealthcare, you can view the following information on *www.myuhc.com* (you will need to register with a user name and password):

- **Personal Profile** — Verify benefits and eligibility. Print a temporary or order a replacement ID card anytime.
- **Provider Search** — Find the physicians and hospitals that are convenient and right for you.
- **Provider Information** — You may view the status of your member eligibility and all claims submitted. You can even send and receive information through the secure mail feature.
- **Claims Inquiry** — View and read the status of all medical claims submitted for payment, including billed charges; any deductibles or co-pays made; the amount paid to the provider; and details on provider payments.
- **Deductible Status** — View all of the co-pays and deductibles paid to date for tax purposes or the amounts accrued towards any plan maximums.
- **Hospital Comparison** — Compare hospitals based on quality of care, procedures, and patient safety measures with the Hospital Comparison tool.
- **Treatment Cost** — Find out and compare what different treatments will cost using the Treatment Cost Estimator, before you need to make a decision.
- **Health Information** — Look up a variety of health conditions, procedures, and topics. You can research a condition for yourself or on behalf of a loved one with the website's evidence-based medical information from the prestigious Healthwise and Best Treatments organizations.
- **Nurseline** — Chat online with registered nurses 7 days a week for trusted information and peace of mind when you have a question or during times when you cannot reach your doctor.
- **Expert Information** — Participate in monthly online events with leading experts in health care.

Medical Plans Comparison Chart

	EPOs	PPOs	
These plans are available to members statewide	RAN+AMN EPO Schaller Anderson Healthcare EPO	Arizona Foundation Medical Care PPO	
In addition to the plans above, the following plans are offered to members in Maricopa, Gila, Pinal, Pima, and Santa Cruz counties	UnitedHealthcare EPO	UnitedHealthcare PPO	
This plan is available to members living out of state.		Beech Street PPO	
DEDUCTIBLE/MAXIMUMS	**In-Network Co-Pay**	**In-Network Co-Pay**	**Out-of-Network Out-of-Pocket**
PCP REQUIRED FOR EACH MEMBER?	NO	NO	NO
PCP REFERRAL REQUIRED TO SEE A SPECIALIST?	NO	NO	NO
PLAN YEAR DEDUCTIBLES INDIVIDUAL MEMBER + ONE / FAMILY	$0 $0	$0 $0	$300 $600
OUT-OF-POCKET MAXIMUMS INDIVIDUAL MEMBER + ONE / FAMILY	$0 $0	$1,000 $2,000	$3,000 $6,000
LIFETIME MAXIMUMS	$0	$0	$2,000,000
PHYSICIAN SERVICES Office Visits/consultations	$10 Max of 1 co-pay/day/provider	$10 Max of 1 co-pay/day/provider	30%* After Deductible
SPECIALIST VISITS (new co-pay)	*$20*	*$20*	*30%* *After Deductible*
PREVENTATIVE CARE Well Baby, Child and Adult Physical Exams, Annual Well-Women Exams (GYN visit & PAP smear test) Annual Well-Man Exams (Office Visit & PSA blood test), Adult Immunizations (e.g., pneumonia, flu)	$10	$10	30%* After Deductible
MAMMOGRAPHY SCREENING (Coverage based on patient age or threat)	$0	$0	30%* After Deductible
OUTPATIENT SERVICES Freestanding ambulatory facility or hospital outpatient surgical center	$0	$0	30%* After Deductible
HOSPITALIZATION SERVICES Room & Board (private room when medically necessary)	$0	$0	30%* After Deductible
Intensive Care	$0	$0	30%* After Deductible
Surgeons and Assistants, Anesthesiologists, Pathologists, Radiologist	$0	$0	30%* After Deductible
EMERGENCY CARE Urgent Center Care	$20	$20	30%* After Deductible
Emergency room (new co-pay)	*$125, waived if admitted*	*$125, waived if admitted*	*$125, waived if admitted*
Ambulance (for medical emergency or required interfacility transport)	$0	$0	Emergency paid at in-network benefit rate
CHIROPRACTIC	$10	$10	30%* After Deductible
PRE-EXISTING CONDITIONS	COVERED	COVERED	COVERED
DURABLE MEDICAL EQUIPMENT	$0	$0	30%* After Deductible
BEHAVIORAL HEALTH			
Outpatient	$10	$10	$10
Inpatient	$0	$0	30%* After Deductible

**Percentages paid based on Reasonable and Customary Charges.*

For the NAU only BCBS PPO plan details, go to http://hr.nau.edu/m/ and choose Benefits, Health, BCBS Plan Book.

This is a Summary only; please see Plan Descriptions for detailed provisions.

How To Use Your Pharmacy Plan

Is there a separate enrollment process for the pharmacy benefit?
If you elect any Benefit Options medical plan, Walgreens Health Initiatives (WHI) will be the network you use for pharmacy benefits. Enrollment is automatic when you enroll in a medical plan, and there is no separate cost.

How does the plan work?
The WHI network consists of more than 62,000 participating chain and independent pharmacies nationwide, with 1,000 member pharmacies in Arizona. All prescriptions must be filled at a network pharmacy or through the mail order service. The cost of prescriptions filled out-of-network will not be reimbursed. To find a pharmacy near your home, work address, out-of-town vacation address, or your dependent student's out-of-state address, refer to *www.mywhi.com*.

Multilingual customer service representatives are available 24 hours a day, 7 days a week at 1.866.722.2141 to assist you.

The WHI plan has a three-tier formulary; the cost for up to a 30-day supply of medication bought at a retail pharmacy is $10 for a generic drug, $20 for a preferred (formulary) drug, and $40 for a non-preferred (non-formulary) drug. You can find information on WHI's formulary and look up the cost for specific drugs at *www.mywhi.com*.

The Walgreens Health Initiatives Preferred Medication List (PML), also known as a formulary, is a list of medications that will allow you to maximize the value of your prescription benefit. These medications, chosen by a committee of doctors and pharmacists, are generics and brand names available at a lower cost than their more expensive brand-name counterparts. The PML is updated quarterly and as needed throughout the year to add significant new medications as they become available.

Medications that no longer offer the best therapeutic value for the plan are deleted from the PML once a year, and a letter is sent to any member affected by the change. To see what medications are on the PML, log on to *www.mywhi.com* or contact the WHI Customer Care Center to have a copy sent to you. Sharing this information with your doctor helps ensure you are getting the medications you need which saves money for you and your plan.

What is the "mail order service" and how do I take advantage of it?
A convenient and less expensive mail order service is available for employees who require medications for on-going health conditions, or who will be in an area with no participating retail pharmacy for an extended period of time. Here are a few guidelines and benefits when using the mail order service:

- You must submit a written 90-day prescription from your physician for any new mail order drug.

- You may request up to a 90-day supply of medication for two co-pays.
- You may fill a 12-month supply of medication with prior authorization.
- You may pay by check or charge your co-pay to a Visa, MasterCard, American Express, or Discover account.
- You may register your email address to receive information on your orders.
- You can order refills online at *www.mywhi.com* or via phone at 1.866.722.2125.
- One-on-one consultations with a licensed pharmacist are also available at this number.

Clinical Prior Authorization

Prescriptions for certain medications or circumstances require clinical approval before they can be filled, even with a valid prescription. Prescriptions may be limited to quantity, frequency, dosage, or may have age restrictions. The authorization process may be initiated by you, your local pharmacy, or your physician by calling WHI at 1.877.665.6609, Monday through Friday, 8:00 a.m. to 8:00 p.m.

Specialty Pharmacy Program

Certain medications used for treating chronic or complex health conditions are handled through the Walgreens Specialty Pharmacy. This program assists you with monitoring your medication needs for certain conditions and by providing patient education. The Specialty Pharmacy Program includes monitoring of specific injectable drugs and other therapies requiring complex administration methods, special storage, handling, and delivery. Call Walgreens Specialty Pharmacy at 1.888.782.8443 for further information on this program.

Medications for these conditions through the Specialty Pharmacy Program include, but are not limited to:

- Anabolic steroids – injectable (Deca-Durabolin®, Virilon IM®);
- Anabolic Steroids - Oral (Anadrol-50®, Android Testred®, Oxandrin®, Winstrol®);
- Anabolic Steroids – Topical (Androderm®, Androgel®, Testoderm®);
- Botulinum Toxins (Myobloc®, Botox®);
- Lamisil®;
- Sporanox®; and
- Penlac®.

The Specialty Pharmacy Program includes but is not limited to the following conditions:

- Cystic Fibrosis
- Rheumatoid Arthritis
- Endometriosis
- Precocious Puberty
- Viral Hepatitis
- Multiple Sclerosis
- Prostate Cancer
- Enzyme Replacement
- Osteoarthritis
- Asthma

Specialty medications are limited to a 30-day supply and may be obtained only at a Walgreens retail pharmacy or via the mail order service. Call WHI at 1.888.782.8443 for further information on this program.

A Specialty Care Representative may contact you to facilitate your enrollment in the WHI Specialty Pharmacy Program. Trained Specialty Care pharmacy staff are available 24 hours a day, 7 days a week, to assist you. You may also enroll directly into the program by calling 1.888.782.8443.

Non-Covered Drugs
Certain medications are not covered as part of the Benefit Options plan. If you find such a drug has been prescribed for you, discuss an alternative treatment with your doctor.

NAU Only BlueCross BlueShield Pharmacy Plan
There is no need to elect or enroll in this plan; it is part of your Medical Plan coverage. Prescription drug benefits are available at four cost-sharing levels. The amount you pay depends on the specific drug dispensed by the pharmacy. The pharmacy will charge you a generic ($7), preferred brand ($20), non-preferred brand A ($40) or non-preferred brand B ($80) co-payment. Drugs may change cost-sharing levels without notice. The BCBSAZ Prescription Medication Guide can be used to determine your co-payment and can be found on the BCBS website at *www.bcbsaz.com/pharmacy* or call 1.800.345.1985.

A mail order benefit is available through Walgreen's mail order service. You may receive up to a 90-day supply of maintenance prescription for one co-payment. The co-payment for a 90-day mail order supply is the same as the co-payment for a 30-day supply through a pharmacy.

More complete information on your prescription drug benefit can be found in the BCBS benefit plan booklet at *www.hr.nau.edu*. Go to Benefits, Health, BCBS Plan Book.

ONLINE FEATURES OF PHARMACY PLAN INFORMATION

Walgreens Health Initiatives (WHI)
All members enrolled in Arizona Foundation, BeechStreet, RAN+AMN, Schaller Anderson Healthcare and UnitedHealthcare can view pharmacy information by registering at *www.mywhi.com*:

- Co-pay and Drug Information — You may research your medication to learn what co-pay is required at retail or through mail-order service.
- Eligibility Information — Check your eligibility status for you and your family members.
- Search the Formulary — You may research medications to determine whether they are generic, preferred or non-preferred drugs. This classification will determine which co-pay is required.
- Download the Formulary — You may print a copy of the formulary to work with your medical provider on locating the right cost-effective medication for you.
- Locate a Nearby Pharmacy — You may view pharmacies in your area by ZIP code or city.
- Prescription History — You may view your entire prescription history, including all of the medications received by each member.
- Mail Service Forms — You may register for mail-order service by downloading the registration form and following the step-by-step instructions.
- Refill Information — You may review refill information, including when your next refill can be ordered and available options to request your next refill.
- Drug Information — You may research information on prescribed drugs to include the uses of the drug, how to use the drug, side effects, precautions, drug interactions, and what to do if there is an overdose.
- Product News — The latest product news is available including drug recalls and industry advances in the pharmaceutical industry.

For the NAU only: More complete information on your prescription drug benefit can be found in the BCBS benefitplan booklet at *www.hr.nau.edu*. Go to Benefits, Health, BCBS Plan Book.

How To Use Your Dental Plan

Following is a brief description of the dental plans available through Benefit Options. For a complete listing of covered services for each plan, please refer to the plan description located on the website, *www.Benefitoptions.az.gov*. Occasionally, covered services and supplies are subject to change based on the American Dental Association Guidelines. These changes may also result in a change to your co-payment.

What plans are available for me to choose from?
Members may choose between two plan types. They are the Prepaid and the Preferred Provider Organization (PPO) plans. If you live outside of Arizona you should select one of the two Indemnity/PPO dental plans. The prepaid plans cover ONLY emergency care outside of Arizona.

Prepaid Plans

- You must see a Participating Dental Provider (PDP) to provide and coordinate all of your dental care.
- No annual deductible or maximums.
- No claim forms.
- No waiting periods.
- Pre-existing conditions are covered.
- Set co-payments for services provided by your general dentist.

Employers Dental Services (EDS)
You must choose one dentist for your family from a network of participating dentists. You can change your dentist at any time by contacting EDS or by using the "change my dentist" function on the website *www.mydentalplan.net*. Members can self refer to Specialists within the network. Specialty services are provided at up to a 25% discount off the Specialist's normal fees. Separate lab fees apply to some services as indicated in the schedule of benefits.

Assurant Employee Benefits
Each family member can choose a different dentist. You can self refer to a Specialty Benefit Amendment (SBA) Specialist in the Network who accepts a co-pay for most common procedures, listed under the SBA. If a procedure is not listed in the SBA co-pay schedule or the Specialist does not participate in the SBA, you will receive a discount off the Specialist's normal retail charges. This discount also includes Orthodontic Services.

Indemnity/PPO Plans

- You may see ANY licensed dentist anywhere in the world.
- Deductible and/or out-of-pocket payments apply.
- You have a maximum benefit of $2,000 per person per plan year for dental services.
- There is a maximum lifetime benefit of $1,500 per person for orthodontia.
- You may need to submit a claim form for eligible expenses to be paid.
- Benefits may be based on reasonable and customary charges.

Delta Dental

Over 80 percent of Arizona's licensed dentists participate in the Delta Dental Plan and agree to accept Delta's allowable fee as payment in full after any deductibles and/or co-payments are met. Amounts billed by network providers in excess of the allowable fee will not be billed to the patient. If you choose to see a non-participating dentist, Delta will still provide benefits, although typically at reduced levels.

MetLife Dental

MetLife participating dental providers accept negotiated fees as payment in full after your deductibles and co-payments are met. These fees are typically 15 to 30 percent below average rates. Non-covered services provided by a participating dentist are also charged at a lower rate. Covered expenses from a non-participating dentist are paid according to established reasonable and customary charges.

Dental Plans Comparison Chart

	Employers Dental Services	Assurant Employee Benefits	Delta Dental	MetLife Dental
PLAN TYPE	Prepaid	Prepaid	Indemnity/PPO	Indemnity/PPO
DEDUCTIBLES	None	None	$50/$150	$50/$150
PREVENTIVE CARE	Co-Pay	Co-Pay	Co-Insurance	Co-Insurance
Office Visit	$5	*$10*	$0 Deductible Waived*	$0 Deductible Waived*
Oral Exam	$0	$0	$0 Deductible Waived	$0 Deductible Waived
Prophylaxis/Cleaning	*$7*	*$5*	$0 Deductible Waived	$0 Deductible Waived
Fluoride Treatment (to age 19)	$0	$0	$0 Deductible Waived	$0 Deductible Waived
X-Rays	$0	$0	$0 Deductible Waived	$0 Deductible Waived
BASIC RESTORATIVE	Co-Pay	Co-Pay	Co-Insurance	Co-Insurance
Office Visit	$5	*$10*	20%*	20%*
Sealant (to age 19)	$12/tooth	*$15/tooth*	20%	20%
Filings	*$13-$30 (amalgam)*	*$20-$45 (amalgam)*	20%	20%
Extractions	*$55 (single)*	*$20 (single)*	20%	20%
Periodontal Gingivectomy	*$225 Per Quadrant*	*$150 Per Quadrant*	20%	20%
Oral Surgery	*$55-$120*	*$20-$135*	20%	20%
MAJOR RESTORATIVE				
Office Visit	$5	*$10*	50%*	50%*
Crowns	*$280 + Lab*	*$265 + Lab*	50%	50%
Dentures	*$325 + Lab*	*$365 + Lab*	50%	50%
Fixed Bridgework	*$280+ Lab*	*$305 + Lab*	50%	50%
Crown/Bridge Repair	*$5 + Lab*	*$25*	50%	50%
Inlays	*$135-$170*	*$230-$305 + Lab*	50%	50%
ORTHODONTIA				
Child	25% discount of Plan Specialist normal retail	25% discount of Plan Specialist normal retail	50%	50%
Adult	25% discount of Plan Specialist normal retail	25% discount of Plan Specialist normal retail	50%	50%
TMJ Services				
Exam, services, etc.	Up to 25% of normal fees	Up to 25% of normal fees	No coverage	No coverage
MAXIMUM BENEFITS				
Annual combined preventive, basic, and major services	No dollar limit	No dollar limit	$2,000/person	$2,000/person
Orthodontia Lifetime	No dollar limit	No dollar limit	$1,500/person	$1,500/person

**Office visit and exams of any type are covered only two times a year at 100%.*

This is a Summary only; please see Plan Descriptions for detailed provisions.

How to Use Your Vision Plan

Coverage for vision examinations and corrective eyewear is available through Avesis, Incorporated. Members are responsible for the full premium cost of this voluntary plan for themselves and their dependents.

You may receive services from either a participating or a non-participating provider once per plan year. Exceptions are the LASIK benefit which is available one time only and only with a participating LASIK center, and additional eyewear benefit which you may use as many times as you wish with a discount within a participating provider's office

Participating Provider
To find a participating provider, either go online to *www.avesis.com* or call Avesis customer service at 1.800.828.9341. Then call the provider and identify yourself as an Avesis member employed by the State of Arizona and schedule your appointment. You can choose to receive your services from a participating optometrist, ophthalmologist or selected retail chain stores.

Participating Provider Fee Schedule	Co-pay	Allowance Given to Employee
1) Vision examination and **one** of the following:	$10	
a) Single, bifocal, trifocal, or lenticular lenses and frame		$100 - $150 allowance
b) Contact Lens*		$130 allowance
c) LASIK Surgery		$150 allowance
2) Options (E.g. Progressive lens, tinting, coatings, transitional lens)		20% discount from provider's fee

* Contact lenses would be covered in full if considered medically necessary.

Non-participating Provider
If services are received from a non-participating provider, you will pay the provider at the time of service and submit a claim to Avesis for reimbursement. The claim must be filed within three months from the date of service and include your name, member ID number and mailing address, the patient's name and date of birth, the group name and number, and an itemized statement of services. An out-of-network reimbursement form is available by visiting the Avesis website at *www.avesis.com*.

NON-PARTICIPATING PROVIDER FEE SCHEDULE

Non-Participating Provider	Allowance Up To:
Vision Examination	$50
Single Vision Lenses	$30
Bifocal Lenses	$45
Trifocal Lenses	$55
Lenticular Lenses	$110
Progressive Lenses	$45
Frames	$50
Contact Lens	
Elective	$150
Medically Necessary	$300
LASIK Surgery	Not Covered

*Member may choose to receive one of the following within their plan period: 1) spectacle lenses and a frame, OR the contact lens benefit. The Contact Lens Benefit takes the place of the exam, lenses and frame within that plan period.

This is a brief description of your voluntary vision care plan available through Benefit Options. For a complete listing of covered services for this plan, please refer to the plan description located on the website, *www.Benefitoptions.az.gov* or contact Avesis directly at 1.800.828.9341.

Blue Cross Blue Shield (NAU only): 1.928.526.0232 or 1.800.423.6484, *www.bcbsaz.com*

Arizona, National and International Coverage
(Medical, Dental, and Vision)

	Within Arizona	Within U.S.	International
MEDICAL			
EPO Plans			
RAN+AMN	Covered in-network	Covered using Beech Street Provider	Emergency and Urgent Only
Schaller Anderson Healthcare	Covered in-network	Covered using Beech Street Provider	Emergency and Urgent Only
UnitedHealthcare	Covered in-network	Covered using UHC EPO provider network	Emergency and Urgent Only
PPO Plans			
Arizona Foundation	Covered in/out-network	Covered using AZF PPO in/out-network or Beech Street Provider	Covered out-of-network
Beech Street	Covered in/out-network	Covered in/out-network	Covered out-of-network
UnitedHealthcare	Covered in/out-network	Covered using the UHC PPO in/out provider network	Covered out-of-network
NAU Only			
BlueCrossBlueShield PPO		Outside AZ: Covered as in-network *only* if you receive covered services from a provider who participates as a PPO provider with the local BCBS plan. For assistance in locating a local BCBS network provider in another state, call 1.800.810.2583.	For assistance with locating a provider and submitting claims, call 1.800.810.2583 or 1.804.673.1686. For an international claim form, go to www.bcbs.com/bluecardworldwide/index.html
PHARMACY			
Walgreens Health Initiatives	Covered in-network	Covered in-network	Not Covered
DENTAL			
Prepaid Plans			
Assurant Employee Benefits	Covered in-network	Emergency Only	Emergency Only
EDS	Covered in-network	Emergency Only	Emergency Only
PPO Plans			
Delta Dental	Covered in/out-network	Covered in/out-network	Covered out-of-network
MetLife Dental	Covered in/out-network	Covered in/out-network	Covered out-of-network
VISION			
Avesis	Covered in-network	Covered out-of-network	Covered out-of-network

Note: Treatment will be subject to the Plan Description.

FLEXIBLE SPENDING ACCOUNTS

Once your employment is terminated:

- You may continue to submit claims for expenses incurred through your termination date but not incurred after your termination date.
- You forfeit any remaining monies unless you elect to continue FSA contributions through COBRA until the end of the plan year.

If you elect to continue FSA through COBRA, your contributions will be post-tax and the amount will be calculated as follows: An additional 2% per pay period for the remaining number of pay periods will be charged in addition to the original pay period amount for administration for FSA under COBRA.

In order to assist you in calculating expenses for medical and/or dependent care, a form has been provided to aid you at *www.benefitoptions.az.gov* under the flexible spending account link for "Employees."

Important Information About Your COBRA Coverage Rights

What is COBRA coverage?
Federal law requires that most group health plans give employees and their families the opportunity to continue their group health coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan and the covered employee/retiree spouse and dependent children enrolled in the group health plan. (Certain newborns, newly adopted children, and alternative recipients under Qualified Medical Child Support Orders (QMCSOs) may also be qualified beneficiaries. This is discussed more in detail in separate paragraphs below).

COBRA coverage is the same coverage that the State of Arizona group health insurance plans (collectively, the "Plan") give to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and HIPAA special enrollment rights.

COBRA (and the description of COBRA coverage contained in this notice) applies only to group health coverage offered by the State of Arizona (the "State") under the Plan (i.e., medical, dental, vision and health care FSA) and not to any other benefits offered by the State (such as life insurance, disability, or accidental death and dismemberment). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this notice is intended to expand your rights beyond COBRA's requirements.

How can you elect COBRA coverage?
To elect COBRA coverage, you must complete the Election Form according to the directions on the Election Form and mail or deliver the completed form by the date specified on the Election Form to the ADOA Benefits Office as indicated on the Election Form. Each qualified beneficiary has a separate right to elect COBRA coverage. For example, the employee's spouse may elect COBRA coverage even if the employee does not. COBRA coverage may be elected for one, several, or for all dependent children who are qualified beneficiaries. A parent may elect COBRA coverage on behalf of any dependent children. The employee or the employee's spouse can elect COBRA coverage on behalf of all of the qualified beneficiaries.

You may elect COBRA under the group health coverages (medical dental, vision and health care FSA) in which you were covered under the Plan on the day before the qualifying event. Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a qualified beneficiary's COBRA coverage will terminate

automatically, if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under another group health plan (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

Electing COBRA under Health Care FSA

COBRA coverage under the health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the health care FSA by the covered employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for health care FSA COBRA coverage that will be charged for the remainder of the plan year. COBRA coverage for the health care FSA, if elected, will consist of health care FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose it rule will continue to apply, so any unused amounts will be forfeited at the end of the Plan year and COBRA coverage will terminate at the end of the Plan year. All qualified beneficiaries who were covered under the health care FSA will be covered together for health care FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate health care FSA annual coverage limit and a separate COBRA premium. If you are interested in this alternative, contact the ADOA Benefits office (see "For More Information" section on page 32).

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA coverage may help you avoid such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of the qualifying event listed above). You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

How Long Will COBRA Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may only be continued for up to a total of 18 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee)

who lose coverage under the Plan as a result of the qualifying event can last up to 30 months from the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination of employment or reduction of hours.

In the case of loss of coverage due to an employee's death, divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the Plan, COBRA coverage may be continued for up to a total of 36 months.

Regardless of the qualifying event, health care FSA COBRA coverage may only be continued to the end of the Plan year in which the qualifying event occurred and cannot be extended for any reason.

This notice shows the maximum period of COBRA coverage available to qualified beneficiaries.

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered after electing COBRA coverage, under another group health plan (but only after any preexisting condition exclusions of another plan that applies to the qualified beneficiary have been exhausted or satisfied);
- the State ceases to provide any group health plan for its employees; or
- during a disability extension (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the applicable carrier (see "For More Information" section on page 32) in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any applicable preexisting condition exclusion). The claims administrator may require repayment of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

How Can You Extend the Length of COBRA Coverage?

If you elect COBRA coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is or becomes disabled or a second qualifying event occurs. You must notify the applicable carriers in writing of a disability or a second qualifying event in

order to extend the period of COBRA coverage.

Failure to provide notice of a disability or second qualifying event will affect the right to extend COBRA coverage. (The period of COBRA coverage under the health care FSA cannot be extended beyond the end of the current Plan year under any circumstances.)

Disability. If any of the qualified beneficiaries is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from the covered employee's termination of employment or reduction of hours (generally 18 months as described above) may be extended up to a total of 29 months. The disability must have started at some time before the 61st day of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours with the State and must last until the end of the 18 month period of COBRA coverage. Each qualified beneficiary who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies. The disability extension is available only if you notify the applicable carrier (see "For More Information" section on page 32) in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination or reduction of hours.

You must also provide this notice within the original 18 months of COBRA coverage obtained due to the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name and contract information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail this notice within the required time periods to the ADOA Benefits Office (see "For More Information" section on page 32).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no disability extension of COBRA coverage. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the applicable carrier of that fact within 30 days after the Social Security Administration's determination. COBRA coverage will end no earlier than the first of the month that begins more

than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as, and include the same information required for, a notice of disability as described above.

Second Qualifying Event. An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the first 18 months (or, in the case of a disability extension, the first 29 months) of COBRA coverage following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date COBRA coverage began. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan.

An extension due to a second qualifying event is available only if you notify the applicable carrier (see "For More Information" section on page 32) in writing of the second qualifying event within 60 days after the date of the second qualifying event.

The notice must include the following information:

- the name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- the second qualifying event;
- the date of the second qualifying event, and
- the signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event, if requested by the ADOA Benefits Office. Acceptable documentation includes a copy of the divorce decree, death certificate, or dependent child(ren)'s birth certificates, driver's license, marriage license or letter from a university or institution indicating a change in student status. You must mail this notice within the required time periods to the ADOA Benefits Office at the addresses indicated on page 32 (see "For More Information" section on page 32).

If the above procedures are not followed or if the notice is not provided within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

How Much Does COBRA Coverage Cost?

Generally, each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The required monthly payment for each group health benefit provided under the Plan under which you are entitled to elect COBRA is noted on the Enrollment/change form.

When (and how) must the first payment for COBRA coverage be made?
If you elect COBRA coverage, you do not have to send any payment with the Election Form.

However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date the Election Form is post-marked, if mailed, or the date of your Election Form is received by the individual at the address specified for delivery on the Election Form, if hand delivered). If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. If your employment ended on January 31st, you would pay for coverage from February 1st through the end of the month in which you are making the payment. You are responsible for making sure that the amount of your first payment is correct. You may contact ADOA Benefits Office to confirm the correct amount of your first payment.

Monthly Payments for COBRA Coverage.
After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each coverage period for each month for each qualified beneficiary is shown in this notice. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Plan will send periodic notice of payments due for these coverage periods (that is, you will receive a bill for your COBRA coverage - it is your responsibility to pay your COBRA premiums on time).

Grace Periods for Monthly Payments.
Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a 30 day grace period after the first day of the month to make each payment for that month. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that month's coverage. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

All COBRA premiums must be paid by check or money order. Your first payment for COBRA coverage should be sent to the following:

Note: Although initial payment is mailed directly to ADOA, payments must be made payable to the applicable insurer for which you are electing coverage.

ADOA Benefits Office
100 N. 15th Avenue, Ste. 103
Phoenix, AZ 85007

Checks should be made payable to:

- UnitedHealthcare for any of the UHC plans
- Fiserv Health - Harrington Benefit Services for any of the following plans: Arizona Foundation, BeechStreet, RAN+AMN, Schaller Anderson Healthcare
- Dental premiums should be made payable to the dental carriers: Delta, MetLife, EDS or Assurant Employee Benefits
- Vision premiums should be made payable to Avesis

After the initial payment, your monthly payments will be sent to the individual administrator/ carrier. You will receive an invoice each month that will include the applicable address.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received. Payments received or postmarked after the due date will not be accepted. You will not be considered to have made any payment if your check is returned due to insufficient funds or otherwise.

More information about individuals who may be qualified beneficiaries.
Children born to or placed for adoption with the covered employee during COBRA coverage period.
A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself and enrolls the child within 30 days of the birth, adoption or placement for adoption.

To be enrolled in the Plan, the child must satisfy the otherwise applicable eligibility requirements (for example, regarding age).

Alternative recipients under QMCSOs.
A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the State during the covered employee's period of employment with the State is entitled to the same rights to elect COBRA as any other eligible dependent child of the covered employee.

For more information
This notice does not fully describe COBRA coverage or other rights under the Plan. More information about COBRA coverage and your rights under the Plan is available from the ADOA Benefits Office.

If you have any questions concerning the information in this notice or your rights to COBRA coverage, you should contact the following:

ADOA Benefits Office
100 N 15th Ave., Suite 103
Phoenix, AZ 85007

602.542.5008 or 800.304.3687.

Information is also available from the:

Centers for Medicare & Medicaid Services (CMS)
Private Health Insurance Group
7500 Security Boulevard
Mail Stop S3-16-16
Baltimore, Maryland 21244-1850
410.786.1565

Keep your plan informed of address changes
In order to protect you and your family's rights, it is important that you keep the ADOA Benefits Office and the applicable health plan administrator(s) informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the ADOA Benefits Office and or the applicable health plan administrator(s).

NOTICE OF THE ARIZONA BENEFIT OPTIONS PROGRAM PRIVACY PRACTICES

The administrators of Arizona Benefit Options know that the privacy of your personal information is important to you. This Notice describes how medical information about you may be used and disclosed, how you may gain access to this information, and the measures taken to safeguard your information. Throughout this Notice, all references to Arizona Benefit Options refer to the administrators of the Program. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION
Arizona Benefit Options may use your health information for purposes of making or obtaining payment for your care, and for conducting health care operations. Arizona Benefit Options has established a policy to guard against unnecessary disclosure of your health information. For purposes of this Notice, health information refers to any information that is considered protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:
To Make or Obtain Payment Arizona Benefit Options may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, Arizona Benefit Options may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations Arizona Benefit Options may use or disclose health information for its own operations to facilitate the administration of Arizona Benefit Options and as necessary to provide coverage and services to all Arizona Benefit Options' participants. Health care operations include activities such as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions.
- Health care professional competence or qualifications review and performance evaluation.
- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
- Reviews and auditing, including compliance reviews, medical reviews, legal services and

compliance programs.

- Business planning and development including cost management and planning analyses and formulary development. In addition, summary health information may be provided to third parties in connection with the solicitation of health plans or the modification or amendment of the existing plan.

As an example, Arizona Benefit Options may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment Alternatives Arizona Benefit Options may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services Arizona Benefit Options may use or disclose your health information to provide you with information on health-related benefits and services that may be of interest to you.

When Legally Required Arizona Benefit Options will disclose your health information when it is required to do so by any federal, state or local law.

To Conduct Health Oversight Activities Arizona Benefit Options may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. Arizona Benefit Options, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings As permitted or required by state law, Arizona Benefit Options may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when Arizona Benefit Options makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes As permitted or required by state law, Arizona Benefit Options may disclose your health information to a law enforcement official for certain law enforcement purposes, including but not limited to if Arizona Benefit Options has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

In The Event of a Serious Threat to Health or Safety Arizona Benefit Options may, consistent with applicable law and ethical standards of conduct, disclose your health information if Arizona Benefit Options, in good faith, believes that such disclosure is necessary to prevent or

lessen a serious and imminent threat to your health and safety or to the health and safety of the public.

For Specified Government Functions In certain circumstances, federal regulations require Arizona Benefit Options to use or disclose your health information to facilitate specific government functions related to the military and veterans, to national security and intelligence activities, to protective services for the president and others, and to correctional institutions and inmates.

For Workers Compensation Arizona Benefit Options may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION
Other than as stated above, Arizona Benefit Options will not disclose your health information without your written authorization. If you authorize Arizona Benefit Options to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION
You have the following rights regarding your health information that Arizona Benefit Options maintains:

Right to Request Restrictions You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on Arizona Benefit Options' disclosure of your health information to someone involved in the payment of your care. However, Arizona Benefit Options is not required to agree to your request.

Right to Receive Confidential Communications To safeguard the confidentiality of your health information, you may request that Arizona Benefit Options communicate in a specified manner or at a specified location. Alternatively, for example, you may request that all health information be mailed to your work location rather than your home. If you wish to receive confidential communications, please make your request in writing. Arizona Benefit Options will accommodate reasonable requests, when possible.

Right to Inspect and Copy Your Health Information You have the right to inspect and copy your health information. If you request a copy of your health information, Arizona Benefit Options may charge a reasonable fee for copying, assembling costs and, if applicable, postage associated with your request.

Right to Amend Your Health Information If you believe that your health information records are inaccurate or incomplete, you may request that Arizona Benefit Options amend the records. That request may be made as long as the information is maintained by Arizona Benefit Options. Arizona Benefit Options may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created

by Arizona Benefit Options, if the health information you are requesting to amend is not part of Arizona Benefit Options' records, if the health information you with to amend falls within an exception to the health information you are permitted to inspect and copy, or if Arizona Benefit Options determines the records containing your health information are accurate and complete.

Right to an Accounting You have the right to request a list of disclosures of your health information made by Arizona Benefit Options for any reason other than for treatment, payment or health operations. The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. Arizona Benefit Options will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. Arizona Benefit Options will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically.

DUTIES OF ARIZONA BENEFIT OPTIONS

Arizona Benefit Options is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. Arizona Benefit Options is required to abide by the terms of this Notice, which may be amended from time to time. Arizona Benefit Options reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If Arizona Benefit Options changes its policies and procedures, Arizona Benefit Options will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to Arizona Benefit Options and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Arizona Benefit Options encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT INFORMATION

For more information or for further explanation of this document, you may contact an Arizona Benefit Options representative at 602.542.5008 (outside the Phoenix area, toll free at 1.800.304.3687), or by email at beneissues@azdoa.gov. You may also obtain a copy of this Notice at our web site at *www.benefitoptions.az.gov*. The ADOA Privacy Officer may be contacted at 100 N. 15th Avenue, Suite 401, Phoenix, Arizona 85007.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

Arizona Department of Administration
Benefit Services Division
100 N. 15th Avenue, Suite 103
Phoenix, AZ 85007

IMPORTANT OPEN ENROLLMENT INFORMATION
ACTION WILL BE REQUIRED